NEW YORK STATE TEAMSTERS COUNCIL
HEALTH & HOSPITAL FUND
APPENDIX A – SCHEDULE OF BENEFITS
SUPREME BENEFITS

PLAN BENEFIT GUIDE	IN NETWORK BENEFITS YOU PAY	OUT OF NETWORK BENEFITS YOU PAY	PAGE # MEDICAL PLAN
PLAN FEATURES			
Primary Care Physician	Not Required		2
Physician Referrals	Not Required		2
Out of Area Benefits	Coverage provided through the BlueCard Network		2
Dependent Coverage	Qualified Dependent Children to age 26		Eligibility Book
Domestic Partner	Not Covered		Eligibility Book
PLAN COST SHARING			
Copayment	$10 Copayment	$10 Copayment and Balance after Allowable Amount	4 / 10
Deductible	$100 Individual / $250 Family Applies ONLY to Durable Medical Equipment / External Prosthetic / Medical Supplies		4 / 10
Coinsurance	0% (20% coinsurance applies to Durable Medical Equipment / External Prosthetic / Medical Supplies)		4 / 9
In Network Providers	A provider that accepts the Allowable Amount as Payment in Full and you will not be balanced billed up to charge		6
Out of Network Providers	A provider that does not accept the Allowable Amount as Payment in Full, may balance bill the patient up to charge		6 / 10
Out of Pocket Maximum	None		10
Total Out-of-Pocket Maximum	None		10
Annual Yearly Limits “Essential Health Benefits”	None		10
Lifetime Maximum	None		10
PHYSICIAN / PROFESSIONAL SERVICES			
Diagnostic Office Visits	$10 Copayment	$10 Copayment and Balance after Allowable Amount	22
Routine Physical Exam – Adult age 19 and older / 1 per calendar year	Covered in Full	Balance after Allowable Amount	22
Routine GYN Exam	Covered in Full	Balance after	21

		Allowable Amount	
PLAN BENEFIT GUIDE	**IN NETWORK BENEFITS YOU PAY**	**OUT OF NETWORK BENEFITS YOU PAY**	**PAGE # MEDICAL PLAN**
Adult – Preventive Care Benefits * See Below for Details	Covered in Full	Balance after Allowable Amount	21
Pregnant Women - Preventive Care Benefits *See Below for Details	Covered in Full	Balance after Allowable Amount	20
Newborns and Children - Preventive Care Benefits *See Below for Details	Covered in Full	Balance after Allowable Amount	21
Well Child Visits and Immunizations - up to age 18	Covered in Full	Balance after Allowable Amount	22
Diagnostic Imaging – X-rays/ Ultrasounds / CAT Scans / PET Scans / MRI	Covered in Full	Balance after Allowable Amount	23
Diagnostic Laboratory and Pathology	Covered in Full	Balance after Allowable Amount	22
Chemotherapy	Covered in Full	Balance after Allowable Amount	23
Radiation Therapy	Covered in Full	Balance after Allowable Amount	23
Kidney Dialysis	Covered in Full	Balance after Allowable Amount	23
Allergy Testing	$10 Copayment	$10 Copayment and Balance after Allowable Amount	23
Allergy Injections & Serum	$10 Copayment	$10 Copayment and Balance after Allowable Amount	23
Chiropractic 20 visits per calendar year	$10 Copayment	$10 Copayment and Balance after Allowable Amount	23
Diagnostic Vision & Hearing Examination	$10 Copayment	$10 Copayment and Balance after Allowable Amount	22
Routine Hearing Examination and Evaluation – Once every calendar year	$10 Copayment	$10 Copayment and Balance after Allowable Amount	22
Diabetes Education	$10 Copayment	$10 Copayment and Balance after Allowable Amount	24 / 25
Surgical Care	$10 Copayment	$10 Copayment and Balance after Allowable Amount	18

Second Medical / Surgical Opinion	$10 Copayment	$10 Copayment and Balance after Allowable Amount	19 / 20
PLAN BENEFIT GUIDE	**IN NETWORK BENEFITS YOU PAY**	**OUT OF NETWORK BENEFITS YOU PAY**	**PAGE # MEDICAL PLAN**
Office Consultation	$10 Copayment	$10 Copayment and Balance after Allowable Amount	23
Injectable Drug – Physicians Office	$10 Copayment	$10 Copayment and Balance after Allowable Amount	24
INPATIENT HOSPITAL SERVICES			
Hospital Benefits **	Covered in Full	Balance after Allowable Amount	5 / 11
Physician Visits in the Hospital	Covered in Full	Covered in Full	21
Surgical Care	Covered in Full	Balance after Allowable Amount	19
Anesthesia	Covered in Full	Covered in Full	19 / 20
Inpatient Consultation	$10 Copayment	$10 Copayment and Balance after Allowable Amount	23
MATERNITY SERVICES			
Inpatient Maternity Care ** (Facility) (Eligible Member / Spouse / Dependent Covered)	Covered in Full	Balance after Allowable Amount	13 / 21
Maternity Care-Prenatal and Postpartum Care – (Physician) (Eligible Member and Spouse ONLY-No Benefits for eligible Dependents)	Covered in Full	Balance after Allowable Amount	20
Newborn Nursery Care (Facility & Physician)	Covered in Full	Balance after Allowable Amount	13 / 20
OUTPATIENT HOSPITAL / FACILITY SERVICES			
Diagnostic Imaging – X-rays/ Ultrasounds / CAT Scans / PET Scans / MRI	Covered in Full	Balance after Allowable Amount	14
Diagnostic Laboratory and Pathology	Covered in Full	Balance after Allowable Amount	14
Surgical Care (Facility & Physician)	Covered in Full	Balance after Allowable Amount	14 / 19
Anesthesia	Covered in Full	Covered in Full	19

Pre-Admission Exam (Physician)	$10 Copayment	$10 Copayment and Balance after Allowable Amount	14
PLAN BENEFIT GUIDE	**IN NETWORK BENEFITS YOU PAY**	**OUT OF NETWORK BENEFITS YOU PAY**	**PAGE # MEDICAL PLAN**
Pre-Admission Testing (Facility)	Covered in Full	Balance after Allowable Amount	14
Injectable Drug – Outpatient Facility	$10 Copayment	$10 Copayment and Balance after Allowable Amount	15
THERAPY SERVICES			
Chemotherapy (Facility)	Covered in Full	Balance after Allowable Amount	14
Radiation Therapy (Facility)	Covered in Full	Balance after Allowable Amount	14
Respiratory and Cardiac Therapy (Facility)	$10 Copayment	$10 Copayment and Balance after Allowable Amount	15
Physical Therapy – 24 visits per calendar year. (Facility & Physician) Combined In and Out of Network	$10 Copayment	$10 Copayment and Balance after Allowable Amount	15 / 19
Occupational Therapy – 24 visits per calendar year. (Facility & Physician) Combined In and Out of Network	$10 Copayment	$10 Copayment and Balance after Allowable Amount	15 / 19
Speech Therapy (Facility & Physician)	$10 Copayment	$10 Copayment and Balance after Allowable Amount	15 / 19
Kidney Dialysis (Facility)	Covered in Full	Balance after Allowable Amount	14
EMERGENCY CARE			
Emergency Room Care – waived if Admitted	$100 Copayment	$100 Copayment and Balance after Allowable Amount	4 / 29
Physician Visit in Emergency Room	$10 Copayment	$10 Copayment and Balance after Allowable Amount	29
Observation Stay – up to 23 hours and in lieu of Inpatient Admission	$100 Copayment	$100 Copayment and Balance after Allowable Amount	13
Urgent Care Center (Facility & Physician)	$10 Copayment	$10 Copayment and Balance after Allowable Amount	28
Ambulance - Ground	Covered in Full	Covered in Full	27 / 28

		Up to Charge	
Ambulance – Air Medical Necessity Applies	Covered in Full	100% up to Allowable Amount UPON REVIEW	27 / 28
PLAN BENEFIT GUIDE	**IN NETWORK BENEFITS YOU PAY**	**OUT OF NETWORK BENEFITS YOU PAY**	**PAGE # MEDICAL PLAN**
MENTAL HEALTH AND CHEMICAL DEPENDENCE			
Inpatient Mental Health **	Covered in Full	Balance after Allowable Amount	3 / 6 / 11
Outpatient Mental Health (Facility & Physician)	$10 Copayment	$10 Copayment and Balance after Allowable Amount	3 / 6 / 14 / 23
Inpatient Chemical Dependence **	Covered in Full	Balance after Allowable Amount	12
Outpatient Chemical Dependence (Facility & Physician)	$10 Copayment	$10 Copayment and Balance after Allowable Amount	15
Inpatient Detoxification **	Covered in Full	Balance after Allowable Amount	12
Physician visits for Inpatient Mental Health, Chemical Dependence & Detoxification	$10 Copayment	$10 Copayment and Balance after Allowable Amount	21
OTHER SERVICES			
Home Health Care ** 40 visits per calendar year Combined In and Out of Network	Covered in Full	Balance after Allowable Amount	16
Skilled Nursing Facility **	Covered in Full	Balance after Allowable Amount	7 / 12
Hospice	Covered in Full	Balance after Allowable Amount	17
Durable Medical Equipment Deductible Combined In & Out of Network	$100 Individual Deductible $250 Family Deductible then processed at 80%	$100 Individual Deductible $250 Family Deductible then processed at 80% and Balance up to Charge	25
Prosthetic Devices Deductible Combined In & Out of Network	$100 Individual Deductible $250 Family Deductible then processed at 80%	$100 Individual Deductible $250 Family Deductible then processed at 80% & Balance up to Charge	13 / 26
Medical Supplies Deductible Combined In & Out of Network	$100 Individual Deductible $250 Family Deductible then processed at 80%	$100 Individual Deductible $250 Family Deductible then processed at 80% and Balance up to Charge	27
Wigs	$300 Limit per Lifetime Balance up to Charge	$300 Limit per Lifetime Balance up to Charge	26

Hearing Aids (Allowance combined between in network, out-of-network, and TruHearing providers)	$4,000 Allowance Adult - every 3 years Children under 13-Allowed every calendar year per EAR	$4,000 Allowance and Balance up to Charge Adult - every 3 years Children under 13-Allowed every calendar year per EAR	27

	Option to buy TruHearing Aids (subject to Allowance and frequency): • TruHearing Advanced Aids- $0 copayment per aid • TruHearing Premium Aids- $300 copayment per aid	
PRESCRIPTION DRUG DETAILED INFORMATION IN THE PRESCRIPTION DRUG BENEFIT PLAN BOOKLET		
RETAIL PHARMACY ACUTE 30 DAY SUPPLY Generic Brand – Preferred Brand – Non- Preferred	 $5.00 Copayment $10.00 Copayment $25.00 Copayment	If a Brand name medication is received and a generic equivalent is available, the participant must pay the Brand name copay PLUS the difference in the cost between the generic equivalent and the Brand name medication.
MAIL ORDER PHARMACY MAINTENANCE 90 DAY SUPPLY Generic Brand – Preferred Brand – Non- Preferred	 $2.00 Copayment $20.00 Copayment $50.00 Copayment	If a Brand name medication is received and a generic equivalent is available, the participant must pay the Brand name copay PLUS the difference in the cost between the generic equivalent and the Brand name medication.

MAIL ORDER – MAINTENANCE PRESCRIPTIONS – Mail Order is Mandatory on all Maintenance Prescriptions otherwise you will be responsible for the full cost of the prescription if purchased at the Retail Pharmacy.

TERMS AND PROCEDURES USED FOR PROCESSING BENEFITS

TERM	PAGE NUMBER LOCATED IN MEDICAL BENEFIT PLAN
ALLOWABLE AMOUNT / EXPENSE	3
IN NETWORK BENEFITS	6
IN NETWORK PROVIDER	6
MEDICAL NECESSITY	8 - SECTION 4
OUT OF NETWORK BENEFITS	6 / 10
OUT OF NETWORK PROVIDER	6
** SERVICES NEEDING PRIOR APPROVAL** • All Services for Organ and Tissue Transplants • All Inpatient Admissions, including Maternity • Skilled Nursing Facility Admissions • Home Care Services	8 / 9
PRIOR APPROVAL PENALTY **A penalty of $500 or 50% of the benefits payable whichever is less, will be imposed if you do not comply with the pre-approval requirements.**	9
PRIOR APPROVAL PROCEDURE	9
FAILURE TO SEEK APPROVAL	9
COURTESY AUTHORIZATION	9

PREVENTIVE HEALTH CARE BENEFITS SUBJECT TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

ADULTS - PREVENTIVE CARE BENEFITS – We will provide coverage for the following preventive care services whether performed in a Facility or in a Professional Provider's office:

- Abdominal Aortic Aneurysm Screening in men aged 65 – 75
- Adult Prevention Exam

- Adult Immunizations-Zoster(Shingles) vaccine age 50 and older
- Alcohol Misuse Screening & Behavioral Counseling Interventions
- Bone Density (Osteoporosis) for women 60 and older
- Breast and Ovarian Cancer Susceptibility & Genetic Risk Assessment and BRCA Mutation Testing
- Breast Cancer Screening - Mammography
- Cervical Cancer Screening – Pap Smear
- Chlamydia Screening for women and pregnant women
- Colorectal Cancer Screening – Colonoscopy, Signomoidoscopy age 50-75
- Prostate Cancer Screening – Exam and PSA Laboratory
- Depression Screening
- Type II Diabetes Screening
- Diet, Behavioral Counseling in Primary Care to promote a healthy diet – Dietician & Physician
- Gonorrhea Screening for women and pregnant women
- High Blood Pressure Screening
- HIV Screening
- Lipid Screening
- Obesity Screening
- Sexually Transmitted Infections Counseling
- Syphilis Infection Screening
- Tobacco Use and Tobacco-Caused Disease Counseling

PREGNANT WOMEN - PREVENTIVE CARE BENEFITS – We will provide coverage for the following preventive care services whether performed in a Facility or in a Professional Provider's office:

- Asymptomatic Bacteriuria Screening (UTI)
- RH (D) Incompatibility Screening
- Daily folic acid supplements for women capable of becoming pregnant
- Hepatitis B Virus Infection Screening
- Breastfeeding, Primary Care Interventions
- Iron Deficiency Anemia Screening
- Sexually Transmitted Infections Counseling
- STD Testing based on risk (other than Chlamydia, HIV)
- Syphilis Infection Screening

NEWBORNS AND CHILDREN - PREVENTIVE CARE BENEFITS – We will provide coverage for the following preventive care services whether performed in a Facility or in a Professional Provider's office:

- Congenital Hypothyroidism Screening in newborns
- Dental Caries in Preschool Children Prevention – less than 6 years
- Major Depressive Disorder Screening in Children and adolescents

- Gonorrhea, Prophylactic Medication for newborns
- Hearing Loss for Newborns
- Iron Supplements for at risk infants 6 – 12 months
- Phenylketonuria Screening in newborns
- Childhood Obesity Screening and Interventions
- Sickle Cell Disease Screening in newborns
- Tuberculosis screening
- Visual Impairment Screening in Children younger than 5 years

PREVENTIVE HEALTH CARE BENEFITS SUBJECT TO THE PROVISIONS OF THE CONTRACT

- Gestational Diabetes Screening
- Human Papillmoavirus Testing – female 30 and over
- Breast Feeding Support, Breast Pump and Counseling
- Contraceptive Methods and Counseling – covered under the Prescription Drug Program

NOTE: If the above services are Routine and billed as Preventive then they are subject to the Patient Protection and Affordable Care Act and may be covered in full with no member responsibility. If the above services are billed with a non-preventive diagnosis then these services will be subject to the provisions of the contract, such as copayments, deductible and coinsurance.